Illinois Department of Healthcare and Family Services
FY2006 Medical Expenditures
For Services Provided in Prior Fiscal Years
Report Required under 30 ILCS 105/25(e)(i)
(in thousands)

Attachment 1

Physicians	**$275,139.0**
Dentists	**22,301.2**
Optometrists	**4,684.3**
Podiatrists	**1,363.5**
Chiropractors	**331.2**
Inpatient/Outpatient	**883,710.6**
Prescription Drugs	**455,411.6**
Long Term Care	**449,665.2**
Community Health Centers	**50,291.3**
Hospice	**22,231.7**
Laboratories	**12,881.4**
Home Health Care	**18,648.0**
Appliances	**24,926.3**
Transportation	**27,101.8**
Other Related	**37,621.8**
HMO's	**8,702.4**
Renal Dialysis Services	**715.4**
Hemophilia Services	**1,980.9**
Sexual Assault Treatment	**1,152.6**
General Revenue and Related Subtotal	**$2,298,860.2**
University of Illinois Hospital Services	**78,518.2**
County Hospital Services	**287,357.1**
Juvenile Rehabilitation Services Medicaid Matching	**1,388.2**
Children's Mental Health	**9,166.9**
Special Education Medicaid Matching	**17,680.9**
TOTAL *	**$2,692,971.5**

* Substance abuse claims, in the amount of $61,466,321 paid by Healthcare and Family Services for prior year claims are included in this total.

Attachment 2

Illinois Department of Healthcare and Family Services
FY 2006
Medical Services for which Claims were Received in Prior Fiscal Years
Report Required under 30 ILCS 105/25(e)(ii)
(in thousands)

Physicians	**$187,683.5**
Optometrists	**4,194.4**
Podiatrists	**717.2**
Chiropractors	**275.1**
Inpatient/Outpatient	**607,956.4**
Prescribed Drugs	**475,207.1**
Long Term Care	**269,424.1**
Community Health Centers	**35,654.3**
Hospice	**10,924.9**
Laboratories	**11,183.6**
Home Health Care	**12,040.0**
Appliances	**18,383.2**
Transportation	**17,454.0**
Other Related	**12,753.6**
HMO's	**42,112.7**
Renal Dialysis Services	**91.5**
Sexual Assault Treatment	**100.0**
University of Illinois Hospital Services	**34,769.7**
County Hospital Services	**59,205.4**
TOTAL	**$1,800,130.7**

Illinois Department of Healthcare and Family Services
Explanation of Variance Between the Previous Year's Estimate and Actual Liabilities and Factors Affecting the Department's Liabilities
Required under 30 ILCS 105/25 (g)(1)(2)

1. **Explanation of the variance between the previous year's estimated and actual Section 25 liabilities.**

   HFS estimates that its base General Revenue Fund and related Section 25 liabilities for FY 2006 will be $1.85 billion, 19.5% lower than the FY 2005 section 25 liabilities.

   At the end of FY 2005, HFS' base General Revenue Fund and related Section 25 liabilities were estimated to be $2.312 billion. FY 2005 actual Section 25 liabilities were $2.3 billion, a difference of $12 million. This 0.5% aggregate variance demonstrates a high degree of accuracy for the FY05 base General Revenue Fund and related Section 25 liability estimates.

   The difference between the estimated and actual liabilities can be attributed to a variety of factors, including use of historic trends between service dates and claim submittal dates, which will have degrees of variance year-to-year.

2. **Factors relating to FY 05 HFS medical liability.**

   Coupled with the success of its medical programs, particularly KidCare and FamilyCare, the Department of Healthcare and Family Services continues to improve client access to quality healthcare, institute cost control measures and achieve funding to support dramatic improvement in annual Section 25 liability.

   The Department implemented cost savings initiatives for FY 2005, which resulted in nearly $50 million in medical liability savings. In FY 2006, another $400 million in cost savings were implemented, resulting in a Medicaid liability growth of only 1.4 %. This was significantly less than the projected national average liability growth of 6.1% for 2006, as reported by the National Association of State Budget Officers (NASBO).

   Children's and working families' health insurance coverage grew in fiscal year 2005 due to eligibility increases in FY 2004, related to FamilyCare/KidCare expansion. In FY 2005, FamilyCare was expanded again to cover families up to 133% of the Federal Poverty Level. As a result, the Kaiser Family Foundation has ranked Illinois #1 in the nation for adding working parents to healthcare and #2 in the nation for adding uninsured children to healthcare. Additionally, there was continued growth in utilization of the SeniorCare provision of pharmacy assistance for seniors.

The Department provided access to health insurance for more than 1.9 million Illinoisans in FY 2005. Illinoisans receiving healthcare through the Department's program included 1.1 million children, 413,000 parents, 145,000 seniors, and 228,000 persons with disabilities.

In FY 2006, HFS provided access to health insurance for more than 2 million citizens. Illinoisans receiving healthcare through the Department's program included 1.2 million children, 457,000 parents, 148,000 seniors, and 234,000 persons with disabilities.

Healthcare and Family Services
Results of the Department's Efforts to Combat Fraud and Abuse
Report Required under 30 ILCS 105/25 (g)(3)

The following information is provided for use in the annual report to the Comptroller and the leadership of the General Assembly as required by 30 ILCS 105/25. Specifically, this information responds to Section (g)(3), which asks for "The results of the Department's efforts to combat fraud and abuse." All statistics are for FY 2006.

Providers

The HFS Office of Inspector General (OIG) Department identified $25.4 million as a result of the completion of 735 provider audits through the audit administrative process for FY 2006. Also during FY 2006, the Department collected $23.2 million from established overpayments determined by completed audits.

The amounts established and recovered by the above efforts amount to a 55% increase (from $16.3 million) in dollars established and a 31% increase (from $17.7 million) in dollars collected when compared to FY 2005. OIG developed computer-driven overpayment identification routines that scan hundreds of millions of services to identify payments in error.

These audits reviewed the billing practices of selected providers enrolled in the Medical Assistance Program. Providers audited included individual practitioners, hospitals, nursing homes, pharmacies, laboratories, transportation entities and other provider types. The most common audit findings were missing records and billing for improper procedure codes.

In FY 2006, fifty-six medical providers were referred to the Medicaid Fraud Control Unit for investigation, six medical providers were terminated, and 5 medical providers voluntarily withdrew from the program as a result of the Department's program integrity efforts.